East of England
Adult Critical Care
Operational Delivery Network

EAST OF ENGLAND

ADULT CRITICAL CARE OPERATIONAL DELIVERY NETWORK

Right Care, Right Place, Right Time

ADULT CRITICAL CARE

REPATRIATION POLICY

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East of England Adult Critical Care Operational Delivery Network

Repatriation Policy

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Contents

1. Summary:

This document outlines the East of England Critical Care Network operational policy for the repatriation of patients from either a specialist critical care unit, or a general adult critical care unit to a local hospital within the East of England Region. Such patients may be transferred to either critical care or a ward area within their local hospital.

1. It is recognised that the repatriation of patients' is necessary to ensure that pathways of care continue without unnecessary delay or interruptions, and supports the NHS objective 'Right Care, Right Place, Right Time'.

1.1. Unnecessary delays are unhelpful in a number of ways.

- They can impede the care pathway for patients requiring rehabilitation.
- They are distressing for both patients and relatives.
- They can contribute to significant delays in unplanned admissions or the cancellation of high-risk elective surgery.
- They can prevent specialist beds from being available.

1.2. This document has been developed collaboratively by members of the East of England Adult Critical Care Operational Delivery Network (EOE ACC ODN) to ensure patients are repatriated to their local hospitals in a timely manner.

1.3. It is recognised that following lessons learnt during the pandemic it may be better for the patient care for local hospitals to arrange transfer to another facility rather than stretching their own resources (capacity transfers). Transfers of this sort are only appropriate when all other avenues have been explored including any delayed discharges resolved.

1.4. Capacity transfers must not be undertaken to facilitate elective work unless this is part of an agreed internal operational policy between hospital sites within the same Integrated Care System, and then only if the individual patient impact is deemed acceptably low by the transferring critical care team at the time of transfer.

2. Scope

2.1. This policy applies to all the trusts within the East of England.

2.2. This policy applies to the management of all adult patients who require repatriation to another acute healthcare provider within the East of England, from either critical care services to critical care or to ward.

2.3. This policy applies to patients whose primary transfer was required for both clinical (specialist care) and capacity reasons.

2.4. This policy applies to adult (over 16 years of age) patients only.

3. Purpose

3.1. To provide a clear and concise description of the procedures and timescales to allow repatriation of patients from specialist areas or from general adult critical care services to local hospital in the East of England either critical care or ward level in a timely manner.

3.2. This policy outlines expectation of all hospitals in the East of England to repatriate patients back to an appropriate local hospital in a timely manner.

3.3. Patients requiring repatriation can be classified under the following broad areas

- Patients whose specialist in patient care completed but requires ongoing hospitalisation available in local hospital regardless of the level of care required in the local hospital.
- Patients who have been transferred from their local hospital due to capacity constraints at that hospital.
- Patients who are taken sick within the East of England and admitted to a hospital that is not their local hospital.

3.4. It is acknowledged that the process for accepting a patient varies from one hospital to another across the ODN. Therefore, all hospitals must have readily available and transparent admission processes and policies in place which do not impede the process of repatriation. Such policies should allow for effective and timely repatriation, these should include process for identification of clinical teams who will accept referrals of patients requiring repatriation. These agreements should be shared with the network for dissemination.

3.5. This policy does not address other transfer issues.

4. Policy Aim

All adult patients, once assessed as clinically fit for transfer by a critical care consultant from the referring centre, will be repatriated within 48 hours from the time of referral to either critical care or to ward level.

4.1. Repatriation will take place once the patient's condition is stable in respect of the specialism which required admission. There must be a clear on-going management plan. The patient has been deemed clinically fit to transfer and is medically safe to transfer (eg critical care to critical care)

4.2. Repatriation of patients transferred for capacity reasons (to critical care) cannot take place until the original hospital is able to receive the patient without this leading to an imminent further transfer due to capacity.

4.3. It is expected that hospitals that have undertaken capacity transfers discuss their position daily with the receiving hospital, and that elective surgical admissions are not accepted within that hospital until the patient is repatriated, unless there is clear agreement from the receiving hospital. Any new patients identified medically fit for ward discharge must be transferred to ward level immediately to accommodate the repatriation.

4.4. In exceptional circumstances more rapid repatriation may be needed to allow specialist centres to continue to offer unimpeded access to speciality beds and local units should make every effort to facilitate this.

4.5. Trusts' will need assistance from their 'Operations Teams' (e.g. Bed/Site Management) to support repatriating patients who have completed their specialist care or are ready to repatriate from critical care services to critical care or ward level in local hospital.

4.6. Repatriation of patients at times becomes complex and requires all Trusts' to work in partnership in the best interest of patients.

4.7. All trusts will keep a record of all repatriation referrals, time of referral from specialist area or general critical care area, when admitted and reasons for refusal or delay.

4.8. Relatives of patients requiring repatriation will be kept fully informed of progress of repatriation and any changes in patient condition, these discussions must be recorded.

4.9. Where possible all patients should have a predicted date of discharge (PDD) established on admission and notified to the identified local hospital.

5. Definitions

Repatriation - Repatriation refers to a patient returning to the local hospital either due to speciality care completed or returning to local hospital to complete in-patient stay either critical care or to ward level

Delayed Repatriation – When a patient has not been repatriated within 48 hours after the first critical care consultant to critical care consultant referral.

Local Hospital – The local hospital is by the address of the General Practitioner at which the patient is registered.

Ward Level – This relates to all inpatient care outside a recognised critical care facility

East of England – This includes the counties of Norfolk, Suffolk, Cambridgeshire, Essex, Hertfordshire and Bedfordshire

CEO – Chief Executive Officer

CCGs – Clinical Commissioning Groups

Clinical transfer – A transfer undertaken to allow a patient to receive specialist care that is unavailable locally.

Capacity transfer – A transfer undertaken because the local hospital is unable to care for the patient due to excess local pressures assuming all other options have been exhausted (elective admissions delayed and delayed discharges resolved).

ICS – Integrated Care System

EoE ACC Transfer Service – East of England adult critical care Transfer Service developed to provide a dedicated equipped transfer clinical team, driver and vehicle to support all transfers of critically ill patients from East of England hospitals (both within region and to facilities in other regions).

6. Operational Arrangements

6.1. Decision Making - Not To Repatriate

6.1.1. For patients whose predicted outcome is futile and likely death imminent within 48 hours; referral back to local hospital should not usually be pursued. Occasionally it may be in the patient's best interests, but such a decision can only be made by a consultant in discussion with the patient (if appropriate) and their family/next of kin and the consultant of the accepting team in accepting hospital.

6.1.2. Patient and relatives must be consulted and kept informed of these decisions. Decisions regarding futility must be consultant led and relatives and patients where possible must be kept informed of these decisions. All discussions with patients and relatives and any decisions made must be recorded in patient records. If repatriation is delayed by 24hours then all discussions with patient and relatives regarding treatment and prognosis must be repeated and again recorded.

6.1.3. On occasion and provided appropriate support is in place, it may be appropriate to transfer a patient directly home.

6.1.4. For patients whose prognosis is poor there must be clear discussion between the transferring unit and the receiving unit. All discussions with patient and relatives at the specialist centre must be recorded prior to transfer.

6.2. Decision Making – Repatriation of Patients to local hospital critical care services

6.2.1. Referring hospital relevant consultant must authorise the Patient's repatriation.

6.2.2. Referring hospital critical care consultant contacts local hospital critical care consultant to accept patient.

6.2.3. When a base speciality consultant (non-critical care) is required in addition in the receiving hospital, then the referring hospital is responsible for making this referral. However, the receiving critical care unit team will recommend the appropriate base speciality consultant/team and how to contact them.
It is the responsibility of the local hospital to have a system in place which allows a base specialist to be identified 7 days a week.

6.2.4. As part of the process for having a patient accepted to a local hospital the referring team should only need to contact one base speciality in addition to the critical care team. This should not delay repatriation.

6.2.5. Document in clinical notes that patient ready for repatriation, date and time of acceptance and the name of the critical care consultant accepting the patient as well as any other teams in the local hospital who have been involved in discussions about the patient. Document discussions held with patient and relatives regarding treatment and prognosis.

6.2.6. Once the patient has been accepted by the local critical care unit, it is acceptable for on-going discussion relating to the timing of the transfer to be undertaken by the senior nurse from the referring critical care unit.

6.2.7. Determining the named consultant /team with responsibility in a local hospital for a repatriated patient must not hinder or delay the repatriation process.

6.2.8. Once a patient is deemed fit for repatriation and safe for transfer and a critical care to critical care consultant referral has been made the patient should be repatriated at the earliest opportunity and not necessary as long as 48 hours following referral.

6.2.9. If a patient becomes unfit to transfer whilst waiting for a critical care bed in another hospital, the 48-hour deadline for repatriation no longer applies. When the patient resumes fitness, the referring hospital must contact the critical care team and any other relevant teams and the clock will restart at zero.

6.2.10. The referring hospital must complete relevant discharge summary / letter, clinical and social information. This must accompany all patients to the accepting hospital. Relevant data should also be transferred electronically as appropriate including radiological investigations. The home local hospital is defined by the address of the General Practitioner at which the patient is registered.

6.2.11. The referring hospital must include a handover of the rehabilitation plan addressing NICE CG83 criteria

6.2.12. Transfer transportation will be organised by the transferring hospital providing necessary escort arrangements, together with all necessary documentation. These transfers are normally within the scope of the East of England ACC Transfer Service who should be contacted on 0333 016 9859.

6.2.13. In accordance with National Standards (D16 Service Specification for Adult Critical Care Services) transfer of patients should be avoided 'out of hours' (2200hrs – 0659hrs).

6.2.14. The clinical responsibility for the patient lies with the referring hospital until the patient arrives in the local hospital and is handed over to the team.

6.3. Decision Making – Repatriation of Patients to ward level.

6.3.1. Referring hospital relevant consultant must authorise the Patient's repatriation.

6.3.2. If the patient is still receiving treatment that could be unavailable at ward level in the receiving hospital it is incumbent on the referring critical care consultant to discuss this with the receiving hospital critical care consultant. Only following confirmation that ward level transfer is feasible should this approach be continued, otherwise the patient should be managed as a critical care to critical care transfer.

6.3.3. Referring hospital critical care consultant contacts local hospital on-call consultant of that day for the relevant speciality.

6.3.4. Document in clinical notes that patient ready for repatriation, date and time of acceptance and the name of the accepting speciality consultant accepting the patient.

6.3.5. Once the patient has been referred to the relevant team in the local hospital, it is acceptable for on-going discussion relating to the timing of the transfer to be undertaken by the senior nurse from the referring critical care unit or the site/bed managers.

6.3.6. Determining the named consultant /team with responsibility in a local hospital for a repatriated patient must not hinder or delay the repatriation process.

6.3.7. As part of the process for having a patient accepted to a local hospital the referring team should only need to contact one accepting team.

6.3.8. Once a patient is deemed fit for repatriation and safe for transfer and a critical care to duty consultant referral has been made in the local hospital; the patient should be repatriated at the earliest opportunity and not necessary as long as 48 hours following referral.

6.3.9. If a patient becomes unfit to transfer whilst waiting for a ward bed in another hospital, the 48-hour deadline for repatriation no longer applies. When the patient resumes fitness, the referring hospital must contacted the on-call

consultant of that day for the relevant speciality and the clock will restart at zero.

6.3.10. The referring hospital must complete relevant discharge summary / letter, clinical and social information. This must accompany all patients to the accepting hospital. Relevant data should also be transferred electronically as appropriate including radiological investigations.

6.3.11. The referring hospital must include a handover of the rehabilitation plan addressing NICE CG83 criteria.

6.3.12. Transfer transportation will be organised by the transferring hospital providing necessary escort arrangements, together with all necessary documentation. If the transfer requires a medical escort it is likely to be within the scope of the East of England ACC Transfer Service who should be contacted on 0333 016 9859.

6.3.13. In accordance with National Standards (D16 Service Specification for Adult Critical Care Services) transfer of patients should be avoided 'out of hours' (2200hrs – 0659hrs).

6.3.14. The clinical responsibility for the patient lies with the referring hospital until the patient arrives in the local hospital and is handed over to the team.

6.3.15. In the case of capacity transfers, by undertaking the original transfer the local hospital and their critical care team agree to support the timely and smooth repatriation of patients to ward level. Delays in this process due to administrative difficulty are unacceptable and will impact on the willingness of other hospitals to offer support.

7. Escalation Procedures

7.1. If repatriation has not occurred within 48 hours with no change in the patient suitability and readiness for transfer this will be recorded as a repatriation delay.

7.2. Referring hospital will maintain communication at least daily regarding the updated position. Once the initial referral (consultant to consultant) has been made this can be undertaken between senior members of the nursing staff, escalating to medical staff when delays occur.

7.3. If repatriation has not occurred within 48 hours, then receiving hospital should consider means of creating extra critical care bed capacity. This should include

opening extra staffed beds, including isolation facilities if necessary. Receiving hospitals will need to escalate to Clinical Directors

7.4. If repatriation has not occurred within 48 hours notification will be given to the 'Operations Team' at the receiving Hospital, and to the Critical Care Network on add-tr.eoeccn@nhs.net.

7.5. Delay in repatriation (Over 72 hours) will be escalated to the Director of Operations to liaise with Director of Operations at receiving hospital for resolution.

7.6. In the event of prolonged delay (over 72 hours) the East Anglia Area Team Specialised Commissioners will be notified of breach of policy for appropriate patients and CCGs for general critical care patients. It may be possible to negotiate transferring patient to a nearby unit temporarily if a prolonged delay is foreseen.

7.7. Any delay of over 96 hours and more then consider holding CEO to CEO discussions.

8. Infection Status

8.1. Infection status must be declared at time of referral.

8.2. Repatriation should not be delayed because a patient's infection status includes those infection control issues that a general critical care unit may be expected to manage on a daily basis eg C*lostridium difficile* & multi-resistant S*taphylococcus aureus* (MRSA).

Units that have a policy to isolate all transfers including those without known infection must ensure that they have adequate isolation facilities to manage and this should not delay repatriation. It is individual trust and Commissioner responsibility to ensure adequate resources. Inadequacy of isolation facilities must be raised with local Clinical Commissioning Groups.

8.3. Infections that a general critical care unit would *either*

1. Not normally be expected to manage regularly eg tuberculosis *or*
2. Be a significant risk to the receiving intensive care environment such as multi-resistant *Acinetobacter baumannii*, Carbapenemase producing *Enterobacteriaceae.*

The isolation of these patients is appropriate, and transfer should take place only when this is available.

9. Communication

Who should:

9.1. Be aware of the document – Trusts, Critical Care Units, Specialised Commissioners, Clinical Commissioning Groups

9.2. Understand the document – Critical Care Units, Trust Operational Teams

9.3. Sign up to the document – Critical Care, Trusts

10. Monitoring Arrangements

10.1. Where the timescale detailed in this policy is not met details of the receiving hospital, length of delay and the reason for delay will be submitted to the East of England Critical Care Operational Delivery Network Office.

10.2. Where recurrent problems are encountered, such as referral difficulties and repatriation delays the proposed receiving hospital will be asked to implement appropriate action to prevent further delays.

10.3. Where frequent or extended delays occur, this will be highlighted to the Operational Delivery Network Board for further escalation.

10.4. Specialised Commissioning - significant delays of over 72hours will be reported through to NHS England - EOE Commissioners. Local Commissioning - then the relevant CCG will be notified.

All units to audit number of referrals and time from referrals to repatriation.

Standard to be measured	**Monitoring Methodology**	**Responsible Area**	**Timescales**	**Reporting Arrangements**
Repatriation of patients within the East of England to either local hospital critical care services or to ward level	All units to audit • Number of referrals • Time of referral to repatriation • Reasons for repatriation delays	Trusts	Quarterly	East of England Critical Care Operational Delivery Network

Send to add-tr.eoeccn@nhs.net

11. Incident Reporting

11.1. All trusts within the East of England Critical Care ODN will continue to operate within their own clinical governance framework and all adverse incidents should be reported in line with their internal governance system.

11.2. Any incidents associated with repatriation and/or transfer should be reported in line with the trusts internal processes along with notifying the relevant ICS and the Network Office.

11.3. Quarterly Reporting of Incidents to the Network Office

- Date of Incident
- Factual account
- Action Taken or Planned
- Outcome
- Supporting evidence if applicable

Send to: add-tr.eoeccn@nhs.net